Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address
MEMORIAL HERMANN HOSPITAL SYSTEM
3200 SOUTHWEST FREEWAY SUITE 2200
HOUSTON TX 77027

Carrier's Austin Representative Box
01

Respondent Name
LIBERTY INSURANCE CORP

MFDR Date Received
JULY 10, 2008

MFDR Tracking Number
M4-08-6690-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary Dated July 9, 2008: "In this case, the carrier paid just 15% of the hospital's usual and customary charges. The carrier has not supplied a copy of any alleged data research, market analysis or other documentation to support their unilateral reduction of the hospital's usual and customary rates and no audit was performed. Due to the nature of the patient's injuries, he required emergency services and supplies during his stay. The hospital billed its usual and customary charge in the total of amount of $22,062.25. Due to the unusually extensive services and supplies provided for this patient's care and treatment, the hospital's usual and customary charges for room and board, ancillary services and supplies and drug charges would be paid at a fair and reasonable rate. Since the carrier did not perform an audit of the charges, Requestor submits that a fair and reasonable rate for treatment of this injured employee is the usual and customary charges incurred. Requestor is owed an additional $18,686.33 plus interest."

Amount in Dispute: $18,686.33

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary Dated July 29, 2008: "Charges were paid per fee schedule requirements at the surgical per diem rate. Additional reimbursement was made for the CT scans which were paid at the fair and reasonable rate of 125% of Medicare allowable. A copy from the Trailblazer's website is attached. Documentation provided does not support that this case would qualify for additional reimbursement as a 'trauma' admission."

Response Submitted by: Liberty Mutual, 2875 Browns Bridge Road, Gainesville, GA 30504

SUMMARY OF FINDINGS

Disputed Dates	Disputed Services	Amount In Dispute	Amount Due
July 10, 2007 Through July 11, 2007	Inpatient Hospital Services	$18,686.33	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.240, 31 *Texas Register* 3544, effective May 2, 2006, sets out the procedures for medical payments and denials.
2. 28 Texas Administrative Code §133.2, 31 *Texas Register* 3544, effective May 2, 2006, sets out the definition of final action.
3. 28 Texas Administrative Code §133.305 and §133.307, 33 *Texas Register* 3954, applicable to requests filed on or after May 25, 2008, sets out the procedures for resolving medical fee disputes.
4. 28 Texas Administrative Code §134.401, 22 *Texas Register* 6264, effective August 1, 1997, sets out the fee guidelines for inpatient services rendered in an acute care hospital.
5. 28 Texas Administrative Code §134.1, 33 *Texas Register* 428, effective January 17, 2008, sets out the guidelines for a fair and reasonable amount of reimbursement in the absence of a contract or an applicable division fee guideline.

The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of Benefits dated January 17, 2008

- 42 – Z710 – No payment exception code description found on the EOB provided.
- 24 – P303 – No payment exception code description found on the EOB provided.
- 150 – Z652 – No payment exception code description found on the EOB provided.

Explanation of Benefits dated April 22, 2008

- 42 – Z710 – THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE ALLOWANCE. (Z710)
- 24 – P303 – THIS SERVICE WAS REVIEWED IN ACCORDANCE WITH YOUR CONTRACT. (P303)
- 150 – Z652 – RECOMMENDATION OF PAYMENT HAS BEEN BASED ON A PROCEDURE CODE WHICH BEST DESCRIBES SERVICES RENDERED. (Z652)

Issues

1. Were the disputed services subject to a specific fee schedule set in a contract between the parties that complies with the requirements of Labor Code §413.011?
2. What are the requirements for reimbursement of the inpatient hospital services per 28 Texas Administrative Code §134.401?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier reduced or denied disputed services with reason code, "24 – P303 – THIS SERVICE WAS REVIEWED IN ACCORDANCE WITH YOUR CONTRACT. (P303)." Review of the submitted information finds insufficient documentation to support that the disputed services are subject to a contractual agreement between the parties to this dispute. The above denial/reduction reason is not supported. The disputed services will therefore be reviewed for payment in accordance with applicable Division rules and fee guidelines.
2. 28 Texas Administrative Code §134.401(c)(1) states "The workers' compensation standard per diem amounts to be used in calculating the reimbursement for acute care inpatient services are as follows: Medical--$870; Surgical--$1,118; Intensive Care Unit (ICU)/Cardiac Care Unit (CCU) -- $1,560." 28 Texas Administrative Code §134.401(c)(2)(A) states "All inpatient services provided by an acute care hospital for medical and/or surgical admission will be reimbursed using a service related standard per diem amount…The complete treatment of an injured worker is categorized into two admission types; medical or surgical. A per diem amount shall be determined by the admission category." 28 Texas Administrative Code §134.401(c)(3)(A)(i and ii) states "Each admission is assigned an admission category indicating the primary service(s) rendered (medical or surgical). The applicable Workers' Compensation Standard Per Diem amount (SPDA) is multiplied by the length of stay (LOS) for admission." 28 Texas Administrative Code §134.401(c)(4)(B)(ii) states "When medically necessary the following services indicated by revenue codes shall be reimbursed at a fair and reasonable rate: (ii) Computerized Axial Tomography (CAT scans) (revenue code 350-352, 359)."

3. Review of the submitted documentation finds that the services provided were surgical; therefore the standard per diem amount of $1,118.00 per day applies. Division rule at 28 Texas Administrative Code §134.401(c)(3)(ii) states, in pertinent part, that "The applicable Workers' Compensation Standard Per Diem Amount (SPDA) is multiplied by the length of stay (LOS) for admission…" The length of stay was one day. The medical per diem rate of $1,118.00 multiplied by the length of stay of one day results in an allowable amount of $1,118.00.

   The division notes that 28 Texas Administrative Code §134.401(c)(4)(B)(ii) states "When medically necessary the following services indicated by revenue codes shall be reimbursed at a fair and reasonable rate: (ii) Computerized Axial Tomography (CAT scans) (revenue code 350-352, 359)." Review of the medical bills finds that the requestor billed $1,673.00 for a CT Scan under revenue code 350. 28 Texas Administrative Code §133.307(g)(3)(D), requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that the requestor does not demonstrate or justify that the amount sought for revenue code 350 would be a fair and reasonable rate of reimbursement. Additional payment cannot be recommended.

   The division concludes that the total allowable for this admission is $1,118.00 per diem. The respondent issued payment in the amount of $3,375.92. Based upon the documentation submitted, no additional reimbursement can be recommended.

Conclusion

The submitted documentation does not support the reimbursement amount sought by the requestor. As a result, no additional reimbursement can be recommended.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	September 18, 2012 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.